Senate

General Assembly

File No. 333

February Session, 2006

Senate Bill No. 386

Senate, April 4, 2006

The Committee on Public Health reported through SEN. MURPHY of the 16th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING REVISIONS TO THE OFFICE OF HEALTH CARE ACCESS STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17a-678 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

[(a)**]** Notwithstanding the provisions of sections 19a-638, as amended, and 19a-639, as amended, (1) a community agency operating a program in a state institution or facility, (2) a nonprofit community agency operating a program, identified as closing a service delivery system gap in the state-wide service delivery plan, in a state institution or facility, and receiving funds from the Department of Mental Health and Addiction Services, or (3) a nonprofit substance abuse treatment facility, identified as closing a service delivery system gap in the state-wide service delivery plan and receiving funds from the department, shall not be required to obtain a certificate of need from the Office of Health Care Access.

[(b) Nothing in subsection (a) of this section shall be construed as creating a certificate of need exemption for the relocation or termination of services.**]**

Sec. 2. Section 17b-856 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

The Department of Social Services may provide grants to hospitals to pay for outreach and eligibility determinations for assistance to families. For the fiscal years ending June 30, 1994, and June 30, 1995, the sum of two million dollars appropriated to the department may be used for said grants and for fiscal years ending June 30, 1996, and subsequent fiscal years, such amount shall be adjusted to reflect the aggregate of inflation in authorized hospital gross revenues determined pursuant to **[**sections 19a-648 and**]** section 19a-649.

Sec. 3. Subsection (c) of section 19a-493b of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(c) Notwithstanding the provisions of this section, no outpatient surgical facility shall be required to comply with section 19a-631, 19a-632, 19a-637a, 19a-644, 19a-645, as amended, 19a-646, **[**19a-648,**]** 19a-649, **[**19a-650, 19a-652,**]** or 19a-654 to 19a-660, inclusive, 19a-662, 19a-664 to 19a-666, inclusive, 19a-669 to 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672 to 19a-676, inclusive, 19a-678, 19a-681 to 19a-683, inclusive. Each outpatient surgical facility shall continue to be subject to the obligations and requirements applicable to such facility, including, but not limited to, any applicable provision of this chapter and those provisions of chapter 368z not specified in this subsection, except that a request for permission to undertake a transfer or change of ownership or control shall not be required pursuant to subsection (a) of section 19a-638, as amended, if the Office of Health Care Access determines that the following conditions are satisfied: (1) Prior to any such transfer or change of ownership or control, the outpatient surgical facility shall be owned and controlled exclusively by persons licensed pursuant to section 20-13, either directly or through a limited liability

company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13, or is under the interim control of an estate executor or conservator pending transfer of an ownership interest or control to a person licensed under section 20-13, and (2) after any such transfer or change of ownership or control, persons licensed pursuant to section 20-13, a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13, shall own and control no less than a sixty per cent interest in the outpatient surgical facility.

Sec. 4. Section 19a-632 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) On or before September first, annually, the Office of Health Care Access shall determine (1) the total net revenue of each hospital for the most recently completed hospital fiscal year beginning October first; and (2) the proposed assessment on the hospital for the state fiscal year. The assessment on each hospital shall be calculated by multiplying the hospital's percentage share of the total net revenue specified in subdivision (1) of this subsection times the costs of the office, as determined in subsection (b) of this section.

(b) The costs of the office shall be the total of (1) the amount appropriated for the operation of the office for the fiscal year, (2) the cost of fringe benefits for office personnel for such year, as estimated by the Comptroller, (3) the amount of expenses for central state services attributable to the office for the fiscal year as estimated by the Comptroller, and (4) the estimated expenditures on behalf of the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, provided for purposes of this calculation the amount so appropriated plus the cost of fringe benefits for personnel, the amount of expenses for said central state services for the fiscal year as

estimated by the Comptroller, and said estimated expenditures from the Capital Equipment Purchase Fund pursuant to section 4a-9 shall be deemed to be the actual expenditures of the office.

(c) On or before December thirty-first, annually, for each fiscal year, each hospital shall pay the office twenty-five per cent of its proposed assessment, adjusted to reflect any credit or amount due under the recalculated assessment for the preceding state fiscal year as determined pursuant to subsection (d) of this section or any reapportioned assessment pursuant to subsection (b) of section 19a-631. The hospital shall pay the remaining seventy-five per cent of its assessment to the office in three equal installments on or before the following March thirty-first, June thirtieth and September thirtieth, annually.

(d) Immediately following the close of each state fiscal year the commissioner shall recalculate the proposed assessment for each hospital based on the costs of the office in accordance with subsection (b) of this section using the actual expenditures made by the office during that fiscal year and the actual expenditures made on behalf of the office from the Capital Equipment Purchase Fund pursuant to section 4a-9. On or before August thirty-first, annually, the office shall render to each hospital a statement showing the difference between the respective recalculated assessment and the amount previously paid. On or before September thirtieth, the commissioner, after receiving any objections to such statements, shall make such adjustments which in said commissioner's opinion may be indicated and shall render an adjusted assessment, if any, to the affected hospitals. Adjustments to reflect any credit or amount due under the recalculated assessment for the previous state fiscal year shall be made to the proposed assessment due on or before December thirty-first of the following state fiscal year.

(e) If any assessment is not paid when due, a late fee of ten dollars shall be added thereto and interest at the rate of one and one-fourth per cent per month or fraction thereof shall be paid on such assessment and late fee.

(f) The office shall deposit all payments received pursuant to this section with the State Treasurer. The moneys so deposited shall be credited to the General Fund and shall be accounted for as expenses recovered from hospitals.

[(g) For the hospital fiscal year commencing October 1, 1993, and for subsequent fiscal years, assessments made under this section, excluding any interest or fee payable pursuant to subsection (e) of this section, shall be included in the computation of net and gross revenue caps for each hospital.**]**

Sec. 5. Section 19a-637a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

On or before February 28, 2004, and each **[**February twenty-eighth**]** March thirty-first thereafter, each short-term acute care general or children's hospital licensed by the Department of Public Health, shall submit to the Office of Health Care Access, in the form and manner prescribed by the office, the hospital's budget for the hospital fiscal year that commenced on October first of the previous calendar year. Said budget shall have been approved by the hospital's governing body and shall contain the hospital's budgeted revenue and expenses and utilization amounts for such fiscal year and any other type of data previously reported pursuant to section 19a-637, as amended, and any regulations adopted pursuant to said section which the office may require.

Sec. 6. Subsection (b) of section 19a-638 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(b) The office shall make such review of a request made pursuant to subdivision (1), (2) or (3) of subsection (a) of this section as it deems necessary. In the case of a proposed transfer of ownership or control, the review shall include, but not be limited to, the financial responsibility and business interests of the transferee and the ability of the institution to continue to provide needed services or, in the case of

the introduction of a new or additional function or service expansion or the termination of a service or function, ascertaining the availability of such service or function at other inpatient rehabilitation facilities, health care facilities or institutions or state health care facilities or institutions or other providers within the area to be served, the need for such service or function within such area and any other factors which the office deems relevant to a determination of whether the facility or institution is justified in introducing or terminating such functions or services into or from its program. The office shall grant, modify or deny such request no later than ninety days after the date of receipt of a complete application, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the office has requested additional information subsequent to the commencement of the review period. The commissioner may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the office. Failure of the office to act on such request within such review period shall be deemed approval thereof. The ninety-day review period, pursuant to this subsection, for an application filed by a hospital, as defined in section 19a-490, as amended, and licensed as a short-term acute-care general hospital or children's hospital by the Department of Public Health or an affiliate of such a hospital or any combination thereof, shall not apply if, in the certificate of need application or request, the hospital or applicant projects either (1) that, for the first three years of operation taken together, the total impact of the proposal on the operating budget of the hospital or an affiliate of such a hospital or any combination thereof will exceed one per cent of the actual operating expenses of the hospital for the most recently completed fiscal year as filed with or determined by the office, or (2) that the total capital expenditure for the project will exceed fifteen million dollars. If the office determines that an application is not subject to the ninety-day review period pursuant to this subsection, it shall remain so excluded for the entire review period of that application, even if the application or circumstances change and the application no longer meets the stated

terms of the exclusion. Upon a showing by such facility or institution that the need for such function, service or termination or change of ownership or control is of an emergency nature, in that the function, service or termination or change of ownership or control is necessary to maintain continued access to the health care services provided by the facility or institution, or to comply with requirements of any federal, state or local health, fire, building or life safety code, the commissioner may waive the letter of intent requirement, provided such request shall be submitted at least ten business days before the proposed date of institution of the function, service or termination or change of ownership or control.

Sec. 7. Subsection (b) of section 19a-639 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(b) (1) The commissioner shall notify the Commissioner of Social Services of any certificate of need request that may impact on expenditures under the state medical assistance program. The office shall consider such request in relation to the community or regional need for such capital program or purchase of land, the possible effect on the operating costs of the health care facility or institution and such other relevant factors as the office deems necessary. In approving or modifying such request, the commissioner may not prescribe any condition, such as but not limited to, any condition or limitation on the indebtedness of the facility or institution in connection with a bond issue, the principal amount of any bond issue or any other details or particulars related to the financing of such capital expenditure, not directly related to the scope of such capital program and within control of the facility or institution.

(2) An applicant, prior to submitting a certificate of need application, shall submit a request, in writing, for application forms and instructions to the office. The request shall be known as a letter of intent. A letter of intent shall conform to the letter of intent requirements of subdivision (4) of subsection (a) of section 19a-638, as

amended. No certificate of need application will be considered submitted to the office unless a current letter of intent, specific to the proposal and in compliance with this subsection, is on file with the office for at least sixty days. A current letter of intent is a letter of intent that has been on file at the office no more than one hundred twenty days, except that an applicant may request a one-time extension of a letter of intent of up to an additional thirty days for a maximum total of up to one hundred fifty days if, prior to the expiration of the current letter of intent, the office receives a written request to so extend the letter of intent's current status. The extension request shall fully explain why an extension is requested. The office shall accept or reject the extension request not later than five business days from the date the office receives the extension request and shall so notify the applicant. Upon a showing by such facility or institution that the need for such capital program is of an emergency nature, in that the capital expenditure is necessary to maintain continued access to the health care services provided by the facility or institution, or to comply with any federal, state or local health, fire, building or life safety code, the commissioner may waive the letter of intent requirement, provided such request shall be submitted at least ten business days before the proposed initiation date of the project. The commissioner shall grant, modify or deny such request not later than ninety days or not later than ten business days, as the case may be, of receipt of such request, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the office has requested additional information subsequent to the commencement of the review period. The commissioner may extend the review period for a maximum of thirty days if the applicant has not filed, in a timely manner, information deemed necessary by the office. Failure of the office to act upon such request within such review period shall be deemed approval of such request. The ninety-day review period, pursuant to this section, for an application filed by a hospital, as defined in section 19a-490, as amended, and licensed as a short-term acute care general hospital or a children's hospital by the Department of Public Health or an affiliate of such a hospital or any

combination thereof, shall not apply if, in the certificate of need application or request, the hospital or applicant projects either (A) that, for the first three years of operation taken together, the total impact of the proposal on the operating budget of the hospital or an affiliate or any combination thereof will exceed one per cent of the actual operating expenses of the hospital for the most recently completed fiscal year as filed with the office, or (B) that the total capital expenditure for the project will exceed fifteen million dollars. If the office determines that an application is not subject to the ninety-day review period pursuant to this subsection, it shall remain so excluded for the entire period of that application, even if the application or circumstances change and the application no longer meets the stated terms of the exclusion. The office shall adopt regulations, in accordance with chapter 54, to establish an expedited hearing process to be used to review requests by any facility or institution for approval of a capital expenditure to establish an energy conservation program or to comply with requirements of any federal, state or local health, fire, building or life safety code or final court order. The office shall adopt regulations in accordance with the provisions of chapter 54 to provide for the waiver of a hearing, for any part of a request by a facility or institution for a capital expenditure, provided such facility or institution and the office agree upon such waiver.

(3) The office shall comply with the public notice provisions of subdivision (4) of subsection (a) of section 19a-638, as amended, and shall hold a public hearing with respect to any complete certificate of need application filed under this section, if: (A) The proposal has associated total capital expenditures or total capital costs that exceed twenty million dollars for land, building or nonclinical equipment acquisition, new building construction or building renovation; (B) the proposal has associated total capital expenditures per unit or total capital costs per unit that exceed one million dollars for the purchase, lease or donation acceptance of major medical equipment; (C) the proposal is for the purchase, lease or donation acceptance of equipment utilizing technology that is new or being introduced into the state, including scanning equipment, cineangiography equipment,

a linear accelerator or other similar equipment; or (D) three individuals or an individual representing an entity comprised of five or more people submit a request, in writing, that a public hearing be held on the proposal and such request is received by the office not later than twenty-one calendar days after the office deems the certificate of need application complete. At least two weeks' notice of such public hearing shall be given to the applicant, in writing, and to the public by publication in a newspaper having a substantial circulation in the area served by the applicant. At the discretion of the office, such hearing shall be held in Hartford or in the area so served or to be served.

Sec. 8. Section 19a-639b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The Commissioner of the Office of Health Care Access or the commissioner's designee may grant an exemption from the requirements of section 19a-638, as amended, or subsection (a) of section 19a-639, as amended, or both, for any nonprofit facility, institution or provider that is currently under contract with a state agency or department and is seeking to engage in any activity **[**, other than the termination of a service or a facility, otherwise**]** subject to said section or subsection if:

(1) The nonprofit facility, institution or provider is proposing a capital expenditure of not more than one million dollars and the expenditure does not in fact exceed one million dollars;

(2) The activity meets a specific service need identified by a state agency or department **[**and confirmed as a current need by the Office of Health Care Access**]** with which the nonprofit facility, institution or provider is currently under contract; **[**and**]**

(3) The commissioner, executive director, chairman or Chief Court Administrator of the state agency or department that has identified the specific need confirms, in writing, to the office that (A) the agency or department has identified a specific need with a detailed description of that need and that the agency or department believes that the need

continues to exist, (B) the activity in question meets all or part of the identified need and specifies how much of that need the proposal meets, (C) in the case where the activity is the relocation of services, the agency or department has determined that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, (D) in the case where the activity is the transfer of all or part of the ownership or control of a facility or institution, the agency or department has investigated the proposed change and the person or entity requesting the change and has determined that the change would be in the best interests of the state and the patients or clients, and (E) the activity will be cost-effective and well managed, and

(4) In the case of a termination of a service or a facility, the commissioner, executive director, chairperson or Chief Court Administrator of the state agency or department with which the nonprofit facility, institution or provider is currently under contract confirms, in writing, to the office that the agency or department has determined that the service needs of the area will continue to be met in a satisfactory manner and specifies how this will be accomplished.

(b) A nonprofit facility, institution or provider seeking an exemption under this section shall provide the office with any information it needs to determine exemption eligibility. An exemption granted under this section shall be limited to part or all of any services, equipment, expenditures or location directly related to the need or location that the state agency or department has identified.

(c) The office may revoke or modify the scope of the exemption at any time following a public review that allows the state agency or department and the nonprofit facility, institution or provider to address specific, identified, changed conditions or any problems that the state agency, department or the office has identified. A party to any exemption modification or revocation proceeding and the original requesting agency shall be given at least fourteen calendar days written notice prior to any action by the office and shall be furnished

with a copy, if any, of a revocation or modification request or a statement by the office of the problems that have been brought to its attention. If the requesting commissioner, executive director, chairman or Chief Court Administrator or the Commissioner of Health Care Access certifies that an emergency condition exists, only forty-eight hours written notice shall be required for such modification or revocation action to proceed.

Sec. 9. Section 19a-639c of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

Notwithstanding the provisions of section 19a-638, as amended, or section 19a-639, as amended, the office may waive the requirements of those sections and grant a certificate of need to any health care facility or institution or provider or any state health care facility or institution or provider proposing to replace major medical equipment, a CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or a linear accelerator if:

(1) The health care facility or institution or provider has previously obtained a certificate of need for the equipment to be replaced; and

[(2) The replacement value or expenditure for the replacement equipment is not more than the original cost plus an increase of ten per cent for each twelve-month period that has elapsed since the date of the original certificate of need; and**]**

[(3)**]** (2) The replacement value or expenditure is less than two million dollars.

Sec. 10. Section 19a-641 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

Any health care facility or institution and any state health care facility or institution aggrieved by any final decision of said office under the provisions of sections 19a-630 to 19a-639e, inclusive, as

amended, [or section 19a-648 or 19a-650,] may appeal from such decision in accordance with the provisions of section 4-183, except venue shall be in the judicial district in which it is located. Such appeal shall have precedence in respect to order of trial over all other cases except writs of habeas corpus, actions brought by or on behalf of the state, including informations on the relation of private individuals, and appeals from awards or decisions of workers' compensation commissioners.

Sec. 11. Subsection (a) of section 19a-643 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The office shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 19a-630 to 19a-639e, inclusive, as amended, and sections 19a-644 [,] and 19a-645, as amended, [and 19a-648,] concerning the submission of data by health care facilities and institutions, including data on dealings between health care facilities and institutions and their affiliates, and, with regard to requests or proposals pursuant to sections 19a-638, as amended, and 19a-639, as amended, by state health care facilities and institutions, the ongoing inspections by the office of operating budgets that have been approved by the health care facilities and institutions, standard reporting forms and standard accounting procedures to be utilized by health care facilities and institutions and the transferability of line items in the approved operating budgets of the health care facilities and institutions, except that any health care facility or institution may transfer any amounts among items in its operating budget. All such transfers shall be reported to the office within thirty days of the transfer or transfers.

Sec. 12. Subsection (a) of section 19a-644 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each

short-term acute care general or children's hospital shall report to the office with respect to its operations in such fiscal year, in such form as the office may by regulation require. Such report shall include: **[**(1) Average salaries in each department of administrative personnel, supervisory personnel and direct service personnel by job classification; (2) salaries**]** (1) Salaries and fringe benefits for the ten highest paid positions; **[**(3)**]** (2) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; and **[**(4)**]** (3) the salaries paid to hospital employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations. **[**In addition, such report may, at the discretion of the office, include a breakdown of hospital and department budgets by administrative, supervisory and direct service categories, by total dollars, by full-time equivalent staff or any combination thereof, which the office may request at any time of the year, provided the office gives the hospital at least thirty days from the date of the request to provide the information.**]**

Sec. 13. Subsection (a) of section 19a-649 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The office, in consultation with the Commissioner of Social Services, shall review annually the level of uncompensated care including emergency assistance to families provided by each hospital to the indigent. Each hospital shall file annually with the office its policies regarding the provision of free or reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices. Each hospital shall obtain an independent audit of the level of charges, payments and discharges by primary payer related to Medicare, medical assistance, CHAMPUS or TriCare and nongovernmental payers as well as the amount of uncompensated care including emergency assistance to families. The results of this audit, including the above information, with an opinion, shall be provided to the office by each hospital **[**together with**]** by March thirty-first of each year, and the hospital's audited financial statements **[**filed on**]** shall be

provided by February twenty-eighth of each year. For purposes of this section, "primary payer" means the final payer responsible for more than fifty per cent of the charges on the case, or, if no payer is responsible for more than fifty per cent of the charges the payer responsible for the highest percentage of charges. The office shall evaluate the audit and may rely on the information contained in the independent audit or may require such additional audit as it deems necessary.

Sec. 14. Section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

As used in sections 19a-659, **[**19a-661,**]** 19a-662, 19a-669 to 19a-672, inclusive, and 19a-676, as amended: **[**19a-677 and 19a-679:**]**

(1) "Office" means the Office of Health Care Access;

(2) "Hospital" means a hospital included within the definition of health care facilities or institutions under section 19a-630, as amended, and licensed as a short-term general hospital by the Department of Public Health and including John Dempsey Hospital of The University of Connecticut Health Center;

(3) "Fiscal year" means the hospital fiscal year;

(4) "Base year" means the fiscal year prior to the fiscal year for which a budget is being determined;

(5) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization;

(6) "Uncompensated care including emergency assistance to families" means the actual cost in the year prior to the base year of care written off as bad debts or provided free under a free care policy approved by the office including emergency assistance to families authorized by the Department of Social Services and not otherwise funded;

(7) "Medical assistance" means medical assistance provided under the state-administered general assistance program or the Medicaid program;

(8) "CHAMPUS" means TriCare or the federal Civilian Health and Medical Program of the Uniformed Services, 10 USC 1071 et seq.;

[(9) "Medicare shortfall" means the Medicare underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(10) "Medical assistance shortfall" means the medical assistance underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(11) "CHAMPUS shortfall" means the CHAMPUS underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;**]**

[(12)**]** (9) "Primary payer" means the payer responsible for the highest percentage of the charges on the case;

[(13)**]** (10) "Case mix index" means a hospital's case mix index calculated using the medical record abstract and billing data submitted by the hospital to the office. The case mix index shall be calculated by dividing the total case mix adjusted discharges for the hospital by the actual number of discharges for the hospital for the fiscal year. The total case mix adjusted discharges shall be calculated by multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for the same diagnosis-related group in

effect for the fiscal year and adding the resultant procedures across all diagnosis-related groups;

[(14)**]** (11) "Contractual allowances" means, for the period October 1, 1992, to March 30, 1994, inclusive, the amount of discounts provided to nongovernmental payers pursuant to subsections (d) and (e) of section 19a-646, for the period beginning April 1, 1994, the amount of discounts provided to nongovernmental payers pursuant to subsections (c), (d) and (e) of section 19a-646 and on and after July 1, 2002, any amount of discounts provided to nongovernmental payers pursuant to a written agreement;

[(15) "Medicare underpayment" means the difference between the actual net revenue of a hospital times the ratio of Medicare charges to total charges and the amount received by the hospital from the federal government for Medicare patients for the year prior to the base year;**]**

[(16)**]** (12) "Medical assistance underpayment" means the difference between the actual net revenue of a hospital times the ratio of medical assistance charges to total charges and the amount received by the hospital from the Department of Social Services for the year prior to the base year;

[(17) "CHAMPUS underpayment" means the difference between the actual net revenue of a hospital times the ratio of CHAMPUS charges to total charges and the amount received by the hospital from CHAMPUS for the year prior to the base year;**]**

[(18)**]** (13) "Other allowances" means the amount of any difference between charges for employee self-insurance and related expenses determined using the hospital's overall relationship of costs to charges;

[(19)**]** (14) "Gross revenue" means the total charges for all patient care services;

[(20)**]** (15) "Net revenue" means total gross revenue less contractual allowance, the difference between government charges and government payments, uncompensated care, and other allowances;

plus, for purposes of compliance, net payments from the uncompensated care pool in existence prior to April 1, 1994, and payments from the Department of Social Services;

[(21)**]** (16) "Emergency assistance to families" means assistance to families with children under the age of twenty-one who do not have the resources to independently provide the assistance needed to avoid the destitution of the child and which is authorized by the Department of Social Services pursuant to section 17b-107 and is not otherwise funded.

Sec. 15. Section 19a-669 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

Effective October 1, 1993, and October first of each subsequent year, the Secretary of the Office of Policy and Management shall determine and inform the Office of Health Care Access of the maximum amount of disproportionate share payments and emergency assistance to families eligible for federal matching payments under the Medical Assistance Program or the Emergency Assistance to Families Program pursuant to federal statute and regulations and subdivisions (2) and (28) of subsection (a) of section 12-407, as amended, subdivision (1) of section 12-408, subdivision (5) of section 12-412, as amended, section 12-414, **[**sections**]** section 19a-649 **[**and 19a-661**]** and this section and the actual and anticipated appropriation to the medical assistance disproportionate share-emergency assistance account authorized pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, as amended, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, as amended, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, **[**19a-661,**]** 19a-662, **[**19a-667**]** 19a-669 to 19a-673, inclusive, and 19a-676, as amended, **[**19a-677 and 19a-679**]** and the amount of emergency assistance to families' payments to eligible hospitals projected for the year, and the anticipated amount of any increase in payments made pursuant to any resolution of any civil action pending on April 1, 1994, in the United

States district court for the district of Connecticut. The Department of Social Services shall inform the office of any amount of uncompensated care which the Department of Social Services determines is due to a failure on the part of the hospital to register patients for emergency assistance to families, or a failure to bill properly for emergency assistance to families' patients. If during the course of a fiscal year the Secretary of the Office of Policy and Management determines that these amounts should be revised, said secretary shall so notify the office and the office may modify its calculation pursuant to section 19a-671 to reflect such revision and its orders as it deems appropriate and the Commissioner of Social Services may modify said commissioner's determination pursuant to section 19a-671.

Sec. 16. Subsection (d) of section 19a-670 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(d) Nothing in section 3-114i, subdivision (2) or (29) of subsection (a) of section 12-407, as amended, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, as amended, subdivision (1) of section 12-414, or sections 12-263a to 12-263e, inclusive, section 19a-646, 19a-659, **[**19a-661,**]** 19a-662 or **[**19a-667**]** 19a-669 to 19a-673, inclusive, and section 19a-676, as amended, **[**19a-677 or 19a-679**]** or section 1, 2, or 38 of public act 94-9* shall be construed to require the Department of Social Services to pay out more funds than are appropriated pursuant to said sections.

Sec. 17. Section 19a-671 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

The Commissioner of Social Services is authorized to determine the amount of payments pursuant to sections 19a-670 to 19a-672, inclusive, for each hospital. The commissioner's determination shall be based on the advice of the office and the application of the calculation in this section. For each hospital, the Office of Health Care Access shall calculate the amount of payments to be made pursuant to sections 19a-

670 to 19a-672, inclusive, as follows:

(1) For the period April 1, 1994, to June 30, 1994, inclusive, and for the period July 1, 1994, to September 30, 1994, inclusive, the office shall calculate and advise the Commissioner of Social Services of the amount of payments to be made to each hospital as follows:

(A) Determine the amount of pool payments for the hospital, including grants approved pursuant to section 19a-168k, in the previously authorized budget authorization for the fiscal year commencing October 1, 1993.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation to the medical assistance disproportionate share-emergency assistance account made pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, as amended, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, as amended, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, **[**19a-661,**]** 19a-662, **[**19a-667**]** 19a-669 to 19a-673, inclusive, and 19a-676, as amended, **[**19a-677 and 19a-679**]** for the quarter subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract the amount of any emergency assistance to families payments projected by the office to be made to hospitals in the quarter.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

(2) For the fiscal year commencing October 1, 1994, and subsequent

fiscal years, the interim payment shall be calculated as follows for each hospital:

(A) For each hospital determine the amount of the medical assistance underpayment determined pursuant to section 19a-659, plus the actual amount of uncompensated care including emergency assistance to families determined pursuant to section 19a-659, less any amount of uncompensated care determined by the Department of Social Services to be due to a failure of the hospital to enroll patients for emergency assistance to families, plus the amount of any grants authorized pursuant to the authority of section 19a-168k.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation made to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, as amended, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, as amended, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, **[**19a-661,**]** 19a-662, **[**19a-667**]** 19a-669 to 19a-673, inclusive, and 19a-676, as amended, **[**19a-677 and 19a-679**]** for the fiscal year, subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract any emergency assistance to families payments projected by the office to be made to the hospitals for the year.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

Sec. 18. Section 19a-672 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

The funds appropriated to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, as amended, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, as amended, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, **[**19a-661,**]** 19a-662, **[**19a-667**]** 19a-669 to 19a-673, inclusive, and 19a-676, as amended, **[**19a-677 and 19a-679**]** shall be used by said account to make disproportionate share payments to hospitals, including grants to hospitals pursuant to section 19a-168k, and to make emergency assistance to families payments to hospitals. In addition, the medical assistance disproportionate share-emergency assistance account may utilize a portion of these funds to make outpatient payments as the Department of Social Services determines appropriate or to increase the standard medical assistance payments to hospitals if the Department of Social Services determines it to be appropriate to settle any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut. Notwithstanding any other provision of the general statutes, the Department of Social Services shall not be required to make any payments pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, as amended, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, as amended, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, **[**19a-661,**]** 19a-662, **[**19a-667**]** 19a-669 to 19a-673, inclusive, and 19a-676, as amended, **[**19a-677 and 19a-679**]** in excess of the funds available in the medical assistance disproportionate share-emergency assistance account.

Sec. 19. Section 19a-676 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

On or before **[**February twenty-eighth**]** March thirty-first of each

year, for the preceding fiscal year, each hospital shall submit to the office, in the form and manner prescribed by the office, the data specified in regulations adopted by the commissioner in accordance with chapter 54, the independent audit required under section 19a-649 and any other data required by the office, including hospital budget system data for the hospital's twelve months' actual filing requirements. **[**The Commissioner of Health Care Access may, at the commissioner's discretion, extend the deadline for submitting such audit and other data beyond February twenty-eighth.**]**

Sec. 20. Section 19a-683 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

There is established a reconciliation account which shall be a separate, nonlapsing account within the General Fund. Any moneys received pursuant to subdivision **[**(2)**]** (3) of subsection (b) of section **[**19a-667**]** 19a-670 shall be deposited by the Commissioner of Social Services into the account.

Sec. 21. Sections 19a-648, 19a-650, 19a-652, 19a-661, 19a-663, 19a-667, 19a-668, 19a-670b, 19a-671b, 19a-677 and 19a-679 of the general statutes are repealed. (*Effective July 1, 2006*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2006*	17a-678
Sec. 2	*July 1, 2006*	17b-856
Sec. 3	*July 1, 2006*	19a-493b(c)
Sec. 4	*July 1, 2006*	19a-632
Sec. 5	*July 1, 2006*	19a-637a
Sec. 6	*July 1, 2006*	19a-638(b)
Sec. 7	*July 1, 2006*	19a-639(b)
Sec. 8	*July 1, 2006*	19a-639b
Sec. 9	*July 1, 2006*	19a-639c
Sec. 10	*July 1, 2006*	19a-641
Sec. 11	*July 1, 2006*	19a-643(a)
Sec. 12	*July 1, 2006*	19a-644(a)
Sec. 13	*July 1, 2006*	19a-649(a)

Sec. 14	*July 1, 2006*	19a-659
Sec. 15	*July 1, 2006*	19a-669
Sec. 16	*July 1, 2006*	19a-670(d)
Sec. 17	*July 1, 2006*	19a-671
Sec. 18	*July 1, 2006*	19a-672
Sec. 19	*July 1, 2006*	19a-676
Sec. 20	*July 1, 2006*	19a-683
Sec. 21	*July 1, 2006*	Repealer section

PH *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 07 $	FY 08 $
Health Care Access, Off.	GF - Revenue Loss	Potential Minimal	Potential Minimal
UConn Health Ctr.	Various - None	None	None

Note: GF=General Fund

Municipal Impact: None

Explanation

This bill makes various changes to law concerning the Office of Health Care Access. Fiscal impacts are as follows:

Sections 1 & 8 authorize the Commissioner of Health Care Access to exempt nonprofit entities under contract with any state agency from certificate of need (CON) review when seeking to terminate a service or facility, provided written confirmation is provided by the agency head that continuing service needs will be met. A corresponding workload reduction will result for the Office. Approximately four fewer CON reviews will be undertaken annually.

This change may facilitate the procurement of services by affected state agencies.

Sections 5, 13 and 19 extend the deadline by which hospitals must submit certain reporting documents from February 28th to March 31st annually. No fiscal impact is associated with these sections.

Sections 6-7 expand the definition of emergency under which the Commissioner may waive the letter of intent requirement associated with a CON request. The Office will experience no fiscal impact as a result of this policy change.

Section 9 authorizes the Commissioner to waive the CON requirement when an entity previously granted a CON for equipment having a replacement value of less than $2 million seeks to replace the equipment at a cost in excess of the original equipment cost indexed upwards by ten percent annually. A minimal number of fewer CON reviews may be required annually. The Office would experience a corresponding workload reduction and minimal revenue loss. [1]

Section 12 modifies certain hospital information that must be submitted to or may be requested by the Office. Its passage will result in no fiscal impact.

Sections 2-4, 10-11, 14-18, 20 and 21 repeal obsolete statutes and make conforming changes. No fiscal impact is associated with these sections.

Provisions in this bill are not anticipated to result in any fiscal impact for John Dempsey Hospital at the University of Connecticut Health Center.

The Out Years

State Impact:

Agency Affected	Fund-Effect	FY 09 $	FY 10 $	FY 11 $
Health Care Access, Off.	GF - Revenue Loss	Potential Minimal	Potential Minimal	Potential Minimal
UConn Health Ctr.	Various - None	None	None	None

Note: GF=General Fund

Municipal Impact: None

[1]A filing fee of $400 would otherwise have been paid when the CON request involved capital expenditures for major medical equipment, imaging equipment or a linear accelerator costing more than $400,000 but less than or equal to $1 million. A filing fee of $1,000 plus .05 percent of the total project cost is paid when an applicant seeks to make a capital expenditure in excess of $1 million.

OLR Bill Analysis
SB 386

AN ACT CONCERNING REVISIONS TO THE OFFICE OF HEALTH CARE ACCESS STATUTES.

SUMMARY:

This bill makes a number of changes to the Office of Health Care Access' (OHCA) certificate of need (CON) program. CON is a regulatory process for reviewing certain proposed capital expenditures by health care facilities, acquisition of major medical equipment, institution of new services or functions, termination of services, transfer of ownership, and decreases in bed capacity. Generally, CON approval is OHCA's formal determination that a health facility improvement, medical equipment purchase, or service change is needed.

The bill amends the CON process by (1) modifying the letter of intent phase of CON in emergency situations, (2) allowing OHCA to waive CON for specific termination of certain services, and (3) modifying the existing waiver from CON for replacement equipment.

The bill makes a number of minor and technical changes to OHCA statutes. It extends the time by which hospitals must report certain information to OHCA, changes some of the salary and benefits data they must report, and modifies their reporting of uncompensated care information. It also repeals several statutory provisions concerning obsolete budget and net revenue system procedures and references to the uncompensated care pool. The uncompensated care pool program has been replaced by the disproportionate share program and OHCA no longer regulates hospital net revenue limits.

EFFECTIVE DATE: July 1, 2006

CON LETTER OF INTENT (§§ 6, 7)

By law, the CON process begins when an applicant submits a "letter of intent" (LOI) to OHCA. It must be filed before the CON application can be submitted. The law requires that the LOI be on file with OHCA for at least 60 days before a CON can be considered submitted

Current law allows OHCA to waive the LOI phase of a CON in an emergency situation so that a health care facility can comply with federal, state, or local health, fire, building, or life safety code requirements. The bill expands this LOI waiver option to emergency situations where the facility must maintain continued access to a health care service it provides. These waivers do not exempt the applicant from CON review, the public hearing, or any other aspect of the CON process.

CON WAIVER FOR SPECIFIC TERMINATION OF SERVICES (§§ 1, 8)

Current law allows OHCA to exempt any nonprofit facility, institution, or provider from CON requirements, other than terminating a service or facility, if certain conditions are met. The bill appears to limit any CON exemption for nonprofits to those under contract with a state agency on department.

It also allows OHCA to grant a CON exemption for nonprofits wanting to terminate a service or facility that are currently under contract with a state agency or department. OHCA can do this if the commissioner, executive director, chairperson, or Chief Court Administrator of the state agency or department contracting with the nonprofit entity confirms in writing to OHCA that the service needs of the area will continue to be met satisfactorily and how this will be done. The bill also exempts from CON Department of Mental Health and Addiction Services–funded alcohol and drug treatment programs seeking the termination or relocation of services.

CON FOR REPLACEMENT EQUIPMENT (§ 9)

Current law allows OHCA to waive CON requirements when a

health care facility, institution, or provider proposes to replace major medical or radiological equipment if:

1. the facility, institution, or provider previously obtained a CON for the equipment being replaced;

2. the replacement value is not more than the original cost plus 10% for each 12-month period that has passed since the original CON; and

3. the replacement value or expenditure is less than $2 million.

The bill repeals the second condition above.

OTHER CHANGES

Report Filing Changes (§§ 5, 19)

The bill extends from February 28 to March 31 the time by which short-term acute general hospitals and children's hospitals must submit budget data to OHCA for the hospital budget year that began the preceding October 1.

The law requires acute care hospitals to submit to OHCA an annual report on their previous fiscal year (which ends on September 30); an audit of their charges, payments and uncompensated care; and hospital budget system data for their 12 months actual filing requirements. The bill extends the reporting deadline from February 28 to March 31 annually, specifies that the audit be independent, and eliminates OHCA's authority to extend the deadline beyond February 28.

Hospital Salary Data (§ 12)

The law requires short-term acute care general and children's hospitals to file annually certain salary and fringe benefit data with OHCA. The bill eliminates a requirement that the report include average salaries of administrative, supervisory, and direct services personnel in each department by job classification. It also repeals a provision that the report, at OHCA's discretion, include a breakdown

of hospital and department budgets by administrative, supervisory, and direct service categories; by total dollars; and by full-time or equivalent staff (CGS § 19a-644(a)).

Uncompensated Care Reporting (§ 13)

By law, OHCA and the Department of Social Services must review annually the level of uncompensated care, including emergency assistance to families, each hospital provides to indigent people. Hospitals must file annually with OHCA their policies on free or reduced cost services to the indigent, excluding medical assistance (Medicaid) recipients, and their debt collection practices. Each hospital must get an independent audit of the level of charges, payments, and discharges by primary payer related to Medicare, Medicaid, and CHAMPUS (the federal Civilian Health and Medical Program of the Uniformed Services). This bill adds TriCare (the Department of Defense's Health Plan for all uniformed services) to this list. It requires hospitals to provide OHCA with the audit results by March 31 annually. It also specifies that the financial statements hospitals must be provided to OHCA annually by February 28 and must be audited financial statements.

BACKGROUND

Medicaid Disproportionate Share Hospital (DSH) Payments

Medicaid DSH payments are additional payments in the Medicaid program that help hospitals finance care to low-income and uninsured patients. Federal law requires state Medicaid programs to take into account the situation of hospitals that serve a disproportionate number of low-income patients when determining payment rates for inpatient hospital care. This is known as the Medicaid DSH adjustment.

Related Bill

HB 5468 increases the CON threshold for all capital expenditures, including major medical equipment, to $3 million dollars.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 23 Nay 0 (03/17/2006)